

Once upon a time, so the story goes, medical representatives were welcomed into surgeries with open arms – even fed a cooked breakfast if you had an early appointment – and given ample opportunity to update the doctor about the disease area and the company's product 'solution'.

Roll on a couple of decades and the pharmaceutical industry is facing a sea-change in its customer base – no longer is the GP or hospital specialist the sole prescriber – the NHS is evolving beyond all recognition, and payers are demanding value for money spent on medicines. For pharma this means a fundamental shift in its sales and marketing strategies and, as a consequence, the last couple of years has witnessed fieldforce numbers tumbling as companies realign with local health economies and look to build relationships rather than using 'share of voice' to bombard the marketplace with promotional and increasingly ineffective messages.

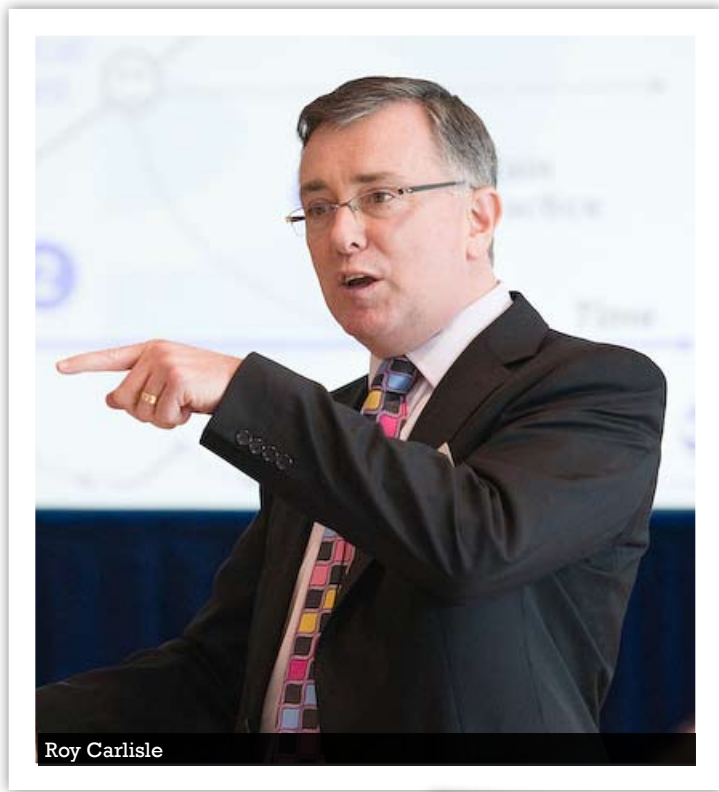
Until recently, between 10,000 and 12,000 representatives were on the road, the idea being that having larger and larger sales teams would mean more customer contact during the critical launch period of a product, more prescriptions written, more revenues generated, and generous rewards for the representatives. Between 1999 and 2004, the top 40 companies doubled their salesforces at a cost of \$875 million to \$1 billion – second



*Roy Carlisle* asks whether there is still a place for the medical representative in the new pharma landscape?



# Death of the pharma salesforce?



Roy Carlisle



only to R&D. But despite high call volumes, sales only grew 15% over this time and there was a significant performance management and ROI issue.

Doctors started restricting representative access and face-to-face calls, with the average interview lasting just two minutes – down from four minutes in 1998 and 12 minutes in 1995 (*Source: Scott Levin Research*). On top of this, only 30% of calls contained a product message and just 13% of doctors could recall any message at all (*Source: RM Consulting*).

The first step was a radical salesforce realignment as local health economies demanded cost-effective, evidence-based medicine, the patient was placed at the centre of the NHS, and additional hurdles to market came into play, for example NICE and the SMC, Scotland's equivalent cost-effectiveness watchdog. On top of this, a strategic shift by pharma from primary to specialist care triggered huge global cutbacks in primary care sales teams.

**‘Between 1999 and 2004, the top 40 companies doubled their salesforces at a cost of \$875 million to \$1 billion’**



**What of the future?**

Physicians still see representatives as a useful source of information, but worry that the information is not always objective or unbiased. A change of approach is needed so, rather than multiple sales teams calling several times on GPs, it will be multidimensional customer focus models including prescribers, payers, commissioners and patients who will need to be influenced. Future representatives will be true business managers, deployed either in primary or specialist care, or in flexible teams dependent on business need, says Carlisle. In order to do this, a different set of skills is required and representatives will need business acumen to make deals with the NHS, high-level of networking skills, an understanding of the principles of market research, and to be financially astute and able to present clinical arguments to secure funding. Understanding the customer and developing a relationship will open doors, and working in partnership will be crucial. If all this is done, the business will follow.